2016-2017 Flu and Pneumo Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *REQUIRED FIELDS

Name: (Last, First, MI)*	Date of birth: * ____ ____ ____ Month Day Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: Include the whole member ID number and any letters that are part of that number

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

*Place Photo Copy of All Insurance Cards Here:

If person getting vaccinated is NOT the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State: *	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission to be vaccinated and for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only:

Date of Service	Vax Type	Vaccine Mfgr (Circle)	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free (Circle)	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV4	Sanofi Pasteur GSK			0.5	Yes No	Yes No	IM	R Arm L Arm	8/7/15	Same as date given
	Fluzone High Dose (IIV3-HD)	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm	8/7/15	Same as date given

IIV4 = Inactivated influenza vaccine, quadrivalent IIV3-HD = Inactivated influenza vaccine, trivalent, high dose

Signature of Vaccine Administrator: X_____

Provider Name: **Natick Board of Health** **MDPH Provider PIN#: 11202**

Provider Address: **13 East Central st, Natick, MA 01760**